SMILECRAFTERS™
DENTAL

Welcome to our office

Please complete all forms (6 pages)

In order to render maximum health service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential, therefore please answer every question and be able to provide identification.

First Name:_____ **Last Name:**_____**(Mr Mrs Ms Dr)**

Street Address:_____

City:_____ **Postal Code:**_____

Date of Birth (d)_____**/(m)**_____ **/(y)**_____ **Gender:** Female / Male

Home phone: _____

Work phone: _____

Cell phone: _____

E-mail address:_____

Marital Status (circle one): **Married** | **Common Law** | **Single** | **Widow**

Preferred method of contact? (check one):

□ **Home #** □ **Cell #** □ **Work #** □ **Email Address**

If under 18 years old:

Parent/Guardian Name_____ → Date of Birth (d)_____/(m)_____ /(y)_____

Do you have a dental plan? Yes No

PRIMARY DENTAL INSURANCE
Subscriber:_____ D.O.B_____

Insurance Company:_____

Group #:_____ Subscriber ID #:_____

SECONDARY DENTAL INSURANCE
Subscriber: _____ D.O.B_____

Insurance Company: _____

Group #:_____ Subscriber ID #:_____

How did you hear about us?

- □ Website
- □ Google
- □ Front Signage
- □ Referral: _____
- □ Patient:_____
- □ Other: _____

Emergency Contact: _____

Telephone:_____ **Relationship:** _____

Family Doctor Name_____ **Phone:**_____

The following information is required to enable us to provide you with the best possible dental care. All the information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the question and explain any that you do not understand. Please fill in the entire form.

Medical history

Please Circle

- Are you in good health? Yes No
- Are you currently seeing a medical doctor? Yes No
- Are you taking any medications, prescribed or self administered? Yes No
  Specify _____
- Do you have any allergies? Yes No
  Specify_____
- Do you bleed or bruise easily? Yes No
- Have you ever been hospitalized? Explain_____ Yes No
- Do you have any kind of heart problem? Explain_____ Yes No
- Have you ever had any conditions or therapy that could affect your immune system? Yes No
  (e.g. HIV positive, AIDS, Leukemia, Radiotherapy, Chemotherapy, Lupus)
- Do you have a prosthetic or artificial joint? (e.g knee or hip) Yes No
- Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes No
- Do you smoke or chew tabacco products? Yes No
- Do you use marijuana? Yes No
- Women only: Are you pregnant? Yes No

Do you presently have or had any of the following: (Please Cirlce)

High/Low blood pressure	Sinus trouble	Heart Attack/Chest pain	Bronchitis
Head or neck injury	Mental/Nervous disorder	Angina	Arthritis
Seizures or epilepsy	Lung disease	Fainting or dizzy spells	Steroid therapy
Asthma	Stomach problems	Depression	Swollen ankles
Stomach Ulcers	Prosthetic heart valves	Thyroid problems	Kidney disease
Drug Dependency	Tuberculosis	Intestinal problems	None of the above
Alcohol Dependency	Diabetes	Cholesterol	
Pacemaker		Cancer	

Have you ever had any other illness not included above? Yes No Other_____

Dental history

When was your last dental visit _____

Have you ever had a dental exam with a full series of X-rays of your teeth and jaws?	Yes No
Were there any complications?	Yes No Explain_____
Have you ever had local anesthetic?	Yes No Complications? _____
Do your gums bleed when:	Brushing Flossing Spontaneously
Do you grind or clench your teeth?	Yes No
Are your teeth sensitive to:	Hot Cold Sweets
Does your jaw crack, pop, or grate when opened widely?	Yes No
Does food lodge between your teeth?	Yes No

OFFICE POLICY (please read)

The efficient operation of our office benefits all patients. Please help us in providing the very best of service by remembering that once you have made an appointment, this time is reserved for you. **At least 48 hours notice must be given if cancellation is absolutely necessary. Patients will be charged $50 for last minute cancellations or no-shows.**

I, the undersigned, certify that all the information given is true to my knowledge and I have not omitted any pertinent information. Also, I consent to the performing of dental and oral surgery procedures that is agreed to be necessary or advisable, including the use of local anesthetic as indicated.

Services are to be paid for at each visit as they are performed. If for certain circumstances the above payment policy cannot be met, special arrangements can be made. I, the undersigned, will assume responsibility for all fees associated with these procedures. I give my authorization to contact me if any accounts are past due.

Signature _____ Date _____ Dr.'s Initial _____

Patient (over 18) or Parent/Guardian

Ancaster|Hamilton|Brantford|Toronto
Email: info@smilecrafters.ca
www.smilecrafters.ca

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention, and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care.

How our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To allow us to efficiently follow -up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- To permit potential purchases, practice brokers or advisors to evaluate the dental practise
- To allow potential purchases, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professionals Appeal and Review Board (HPARB)
- To invoice for good and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements to comply generally with the law

By signing the consent section of the Patients Consent Form, you have agreed that you have given your informed contact to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental of Ontario fulfilling its mandate under RHPA, and for the defence of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that **SmileCrafters Dental** can collect, use and disclosure personal information as set out above in the information about the office's privacy policies.

_____ _____

Signature **Print Name**

_____ _____

Date **Signature of Witness**

We're Now Digital!

SmileCrafters Dental sends electronic (email/text) communications which may include appointment confirmations, newsletters, upcoming events and important notifications. I agree to receive future electronic communication for us? **YES/NO (please circle)**

You can withdraw your consent at any time.

Patients Name: _____

Patients Cell Phone Number:_____

Patients Email:_____